PROVIDER INQUIRER

March 1st, 2005 www.michigan.gov/mdch

Featured Articles

Billing Coordination of Benefit (COB) Codes

Medicaid understands that COB billing can sometimes be a little complicated. Medicaid would like to have providers utilize the information that is available on our website and within our manual so that your claims can be paid correctly.

Before billing COB, it is helpful to understand a little about it.

COB is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments. Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries.

Medicaid rejects many claims because of improper code use in Box 24J of the HCFA 1500 form**. In order for MDCH to properly adjudicate Medicaid paper claims, the appropriate codes must be used and other insurance Explanation of Benefit's must be included.** All electronic claims are coded specific to the software that is being used.

The COB codes and their descriptions are listed in the Medicaid Provider Manual. The COB codes can be found in the Billing & Reimbursement for Professionals chapter, section 3.1 Claim Completion Instructions. Additional information can also be found in the Coordination of Benefits chapter. Any questions on the proper use of COB codes, please contact the Provider Inquiry Line at 1-800-292-2550. **See Medicaid COB Tips below:**

- Medicaid identifies Medicare COB codes separately from other insurance COB codes.
- One COB code must be entered in Box 24J on each appropriate claim line.
- COB 7 should be reported when the entire charge is applied to the Medicare deductible.
- COB 5 should be reported when a Medicare payment is applied to the charges or a portion of the charge is applied to deductible and Medicare made a payment.
- Medicaid expects that all payments will be reported in Box 24J.
- COB 2 should be reported to show a fixed co-pay from a commercial HMO. Item 24F should be the fixed co-pay amount only.
- Only payment amounts should be entered in Box 24K.
- COB 8 is reported to show terminated coverage that Medicaid still has in the system.

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Tertiary Claim Submission

Effective immediately, please discontinue sending paper tertiary claims to Revenue and Reimbursement as previously instructed. All Medicaid tertiary (third payer) claims can be submitted directly to the invoice processing system at:

Michigan Medicaid
PO Box 30043
Lansing, MI 48909

The systems problem that prevented tertiary claims from processing through normal channels has been identified and corrected. Special processing of claims with Commercial insurance, Medicare and Medicaid as tertiary is no longer required.

Make sure to review the section on Coordination of Benefit (COB) Codes. Medicaid will require that the proper COB codes be reported. COB Code 4 reports that both Medicare and another carrier made a payment. The total payment amount should be reported in Box 24K.

The same rules apply for sending secondary paper claims to Michigan Medicaid. All Explanation of Benefits (EOBs) will need to be included.

If providers are billing claims electronically, these claims can continue to be sent electronically. An electronic claim submission of secondary or tertiary claims does not require EOBs to be attached. The electronic claim format allows for specific fields to report other insurance information per claim line.

If your software vendor or billing agent is not set up for billing secondary or tertiary claims and would like to receive more information, please contact AutomatedBilling@michigan.gov.

Provider Address Change

Providers are reminded that they must notify the Provider Enrollment Unit whenever they change their service or billing address.

When a change of address occurs, the provider may submit notification through fax (517) 241-8233 or mailed to:

MDCH Provider Enrollment
PO Box 30238
Lansing, MI48909

Within your notification please include the previous address, the new address, Medicaid billing ID, and the address for which the provider continues to receive the Medicaid warrants.

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Revenue and Reimbursement

The Revenue and Reimbursement Unit notifies providers when Medicaid has made a payment on claims and subsequently determines the beneficiary was eligible for Medicare.

If the provider receives this notification, the provider should then bill Medicare for the charges incurred by the patient. Once Medicare makes a payment, the provider then can bill Medicaid secondary to Medicare. This will need to be billed as a claim replacement for the co-insurance or deductible amount after Medicare has been billed. Please remember that the billing limitations for Medicaid still apply.

If the provider takes no action after the notification the Revenue and Reimbursement Unit will enter a mass claim adjustment. This claim adjustment will recover the money to Medicaid.

After the money is recovered and the provider determines that the beneficiary was not eligible for Medicare, a claim replacement must be submitted. The Revenue and Reimbursement Unit will not submit the replacement claim.

Any questions on this process or how to submit a replacement claim, please contact the Provider Inquiry Area at 1-800-292-2550.

Electronic 837 Institutional Claim Submission Details

When submitting claims electronically there are a few different guidelines to follow. All of these guidelines can be found within our Electronic Billing Website. To view the information, please visit www.michigan.gov/mdch >> Providers >> Information for Medicaid Providers >> Electronic Billing.

Medicaid requires that the appropriate type of bill must be reported in form locator 4 of the UB92. Medicaid currently monitors the third digit for the appropriate adjudication procedures.

MDCH recommends submitting 50 or fewer service lines for each institutional claim. Claims submitted with more than 50 service lines may be subjected to processing delays.

To prevent unnecessary pend edits and inappropriate payment of claims, providers should limit the number of claim lines billed to 50 claim lines per claim.

If you have any electronic billing questions, please email AutomatedBilling@michigan.gov.